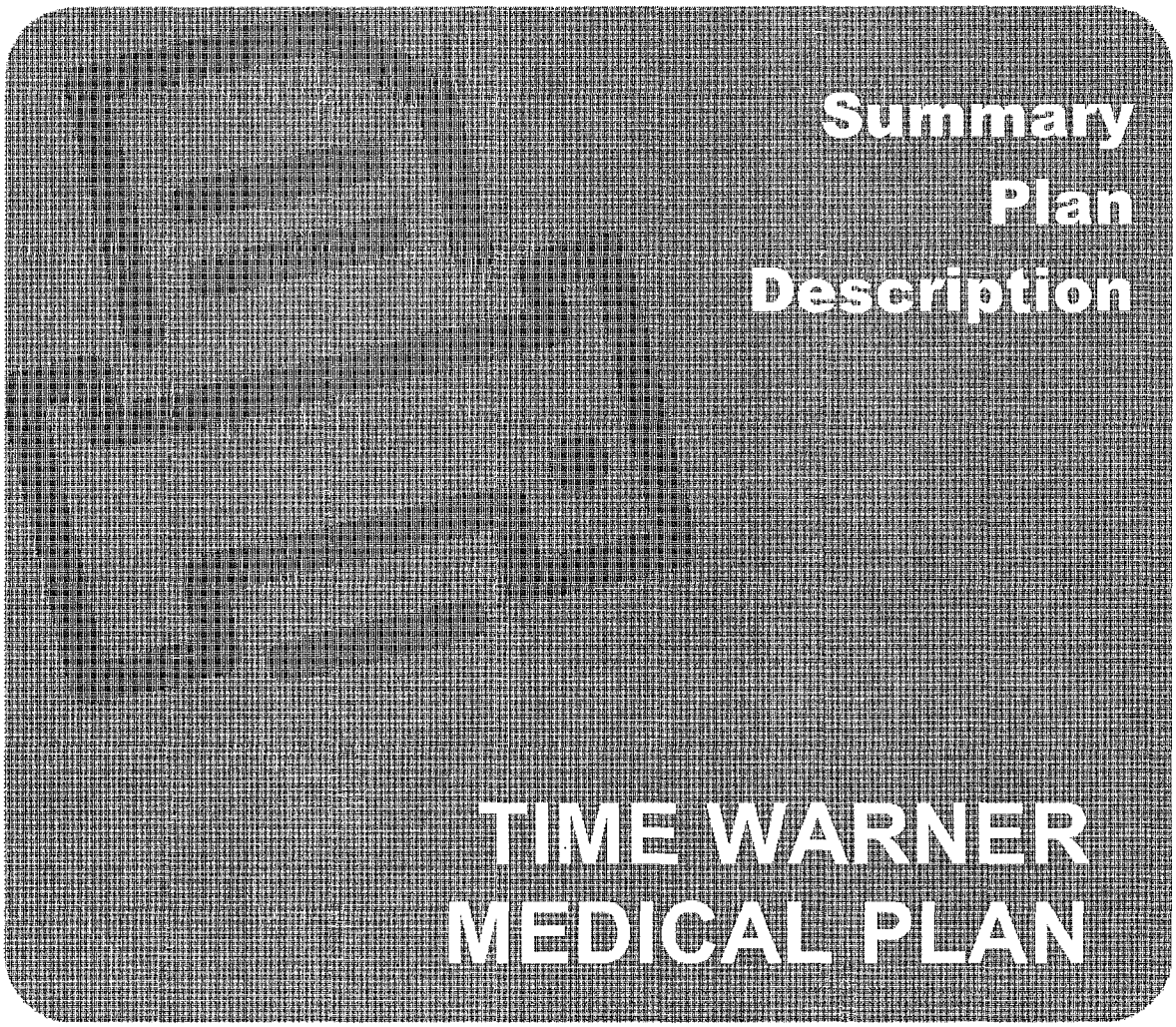
EXHIBIT 12



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acknowledgment, agreement, authorization, or waiver or release that the Plan Administrator or Claims Administrator deems necessary to exercise the Plan's rights and/or privileges under the Plan; or may offset present or future benefits payable under the Plan to or on behalf of you or your dependents, regardless of whether such benefits are related to the subject illness or injury.

The company that contacts you about a possible subrogation claim may be a third-party company under contract with a Claims Administrator.

Qualified Medical Child Support Orders

The Plan provides benefits in accordance with the requirements of any Qualified Medical Child Support Order ("QMCSO"). A QMCSO includes a judgment, decree or order (including a settlement agreement or administrative notice) issued either by a domestic relation or other court of competent jurisdiction, or through an administrative process established under state law and that has the force and effect of law under state law. This means that when a state agency issues a medical child support order — otherwise satisfying the QMCSO requirements in section 609(a) of ERISA — it must be honored by a group health plan.

This provision permits state courts (or state agencies) to require an employer that provides dependent health coverage to make that coverage available to a participant's child even though the child is not a legal dependent because of a separation or divorce.

To get a free copy of the procedures the Company follows in the event a QMCSO is issued, contact your Employee Benefits/Human Resources Department.

States' Rights and Participants Who Are Eligible for Medicaid

Under Section 609(b) of ERISA, the Plan is subject to any state's right to reimbursement for medical benefits that the state has paid on behalf of a covered participant, if the participant is covered by a state's Medicaid program and if the benefits paid by the state would have been covered by the Plan. In providing benefits or enrolling an employee, the Plan may not take into account an individual's eligibility for medical assistance under a state's Medicaid program.

Claim Fraud

The Claims Administrators regularly evaluate claims to detect fraud or false statements and will notify the Company regarding these matters. The Claims Administrator must be advised of any discounts or price adjustments made to you by any provider. A provider who waives or refunds amounts that are your responsibility under the Plan (such as your coinsurance amount) is entering into a discount arrangement with you. The Claims Administrator calculates the benefit payment based on the amount actually charged, less any discounts, rebates, waivers or refunds of coinsurance amounts or deductibles you receive. Failure to notify your Claims Administrator or the Plan Administrator of such price adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan.

If a claim has been submitted for payment or paid by the Plan as a result of fraudulent representations, the Claims Administrator or the Plan Administrator may seek reimbursement and may elect to pursue the matter by pressing criminal charges.

Compliance with Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, and current federal tax law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law "pre-empts" (that is, takes precedence over) state law.

Collective Bargaining Agreements

The Plan and the Program may also be referred to in any collective bargaining agreements entered into by, or applicable to, Turner. You can ask your Employee Benefits/Human Resources Department whether a collective bargaining agreement applies to you.

Ownership of Benefits

The benefits described in this Summary Plan Description are exclusively for Program participants or their beneficiaries. Program benefits cannot be sold, transferred or assigned for any reason except as provided by law or as described under Assignment of Benefits (under Other Information You Should Know).

Plan Administration

Your benefits as a participant in the Program are provided under the terms of this Summary Plan Description and the insurance policies and/or contracts, if any, issued to the Company. The Program is maintained for the exclusive benefit of Plan and Program participants and their beneficiaries. The Plan Administrator has exclusive authority and sole and absolute discretion to interpret the Plan and the Program, to determine eligibility for benefits, and to make any factual determination, resolve factual disputes, and decide all matters in connection with the interpretation, administration and operation of the Plan and the Program in order to determine the eligibility for benefits.

The applicable Claims Administrator has complete authority and sole and absolute discretion to interpret the Plan and the Program, to make any factual determination, to resolve factual disputes, and decide all matters in connection with the interpretation, administration and operation of the Plan and the Program in order to determine whether you have incurred a covered expense for which benefits may be payable under the Plan and the Program and to determine the amount of, and administer the payment of, any such benefits under the Plan and the Program.

Benefits will be paid under the Plan only if the Plan Administrator or the applicable Claims Administrator, as appropriate, determines in its discretion that the claimant is entitled to them. Decisions of the Plan Administrator and the applicable Claims Administrator will be conclusive and binding upon all similarly situated individuals having an interest in the Plan.